Welcome

Welcome to this week’s edition of BC Disease News.

In the last week, it has been revealed that the Department of Health now only intend to introduce fixed recoverable costs for clinical negligence cases worth up to £25,000 as opposed to the originally intended £100,000. Elsewhere, a regional costs judge has ruled that a budget did not fetter his discretion on detailed assessment.

This week we present a feature article which considers whether NIHL claims handling schemes based upon a single audiogram would simplify and speed up the claims process and reduce claim costs?

Any comments or feedback can be sent to Boris Cetnik or Charlotte Owen.

As always, warmest regards to all.

SUBJECTS

Jackson Shuns Standard Directions For Disclosure

In a lecture at the Law Society’s commercial litigation conference last week, Lord Justice Jackson addressed the topic of disclosure and considered whether more effective use should be made of the rules which have been in place since 2013.

Disclosure can be a costly exercise, not only due to the process of identifying and handing over appropriate documents but also considering bundles from the other side which can be a lengthy process. Therefore, says LJ Jackson, getting a grip on disclosure is one of the keys to controlling litigation costs.

He went on to say that often, people are treating standard disclosure as the default option, with parties frequently agreeing it, seemingly without considering whether other options may be preferable, and the courts accept their agreements. However, it was suggested that it would be to the public benefit if all involved in the disclosure process gave more attention to the full range of options before simply proposing or agreeing to ‘standard disclosure’. These options include, e-disclosure, predictive coding and other types of technology assisted review.

In particular it was noted that more use should be made of CPR r. 31.5 (7) which contains the ‘menu’ of different possible disclosure orders. One possible form of order, which is not expressly set out but which is sometimes made under rule 31.5(7)(f), gives, by consent of each party, the other free access to all its documents (other than privileged documents), so that they can pick out whichever ones they want.

However, it was not just the parties to proceedings that needed to adapt their approach to disclosure. He said judges needed to do more than simply adjudicate upon the parties’ competing submissions:

‘It is necessary to test the opposing arguments’.

He quoted the experience of one unnamed judge:

‘When disclosure is an issue during case management, it is not uncommon to find that the parties’ counsel cannot describe the documents which they expect to be relevant, why they might exist or why they will benefit determination of the issues concerned. This is particularly the case for electronic documents, when requests for practical descriptions and examples are usually met with bluster’.

Despite the fact that this discussion was had in reference to commercial litigation, it is applicable to all areas of civil litigation.

The full speech can be found here.

Changes For Fixed Fees In Clinical Negligence Claims

It has been well documented in BC Disease News that the government initially intended to introduce fixed fees for clinical negligence claims worth at least £100,000 from 1 October 2016 with a consultation on the plan being due since autumn 2015. Whilst this deadline for implementation has been and gone and we are still awaiting the publication of the consultation (which is said to be imminent!), it has been revealed this week that the Department of Health (DoH) has amended its position.

The Civil Procedure Rule Committee (CPRC) held a meeting in July, the minutes of which have recently been released, and they reveal that the DoH now only intend to introduce fixed recoverable costs for those clinical negligence cases worth up to £25,000.

Amanda Stevens, chair of the CPRC subcommittee, reported the news and noted that these claims comprised approximately 60% of all clinical negligence claims. She said:

‘The material worked up by the subcommittee on a draft protocol and illustrative rules would be amended accordingly. The date of publication of the consultation was unknown’.

Organisations such as, the Association of Personal Injury Lawyers (APIL), the Law Society and the Society of Clinical Injury Lawyers have been lobbying the government since these proposals were announced in August 2015, accusing the DoH of being irresponsible. It is thought that this change in approach will be seen as a significant win for them.

APIL president, Neil Sugarman stated:

‘…it would show that the government has listened to arguments that a quarter of a million pounds is not a low-value case, and that cases of such magnitude do not suit a fixed process. A fixed-fee system for cases up to £25,000, however, could be workable. The fees would have to be fixed at a level which makes the work viable, and the process itself must also be fixed’.

He continued:

‘Other conditions, such as admission of liability and requirement of just one medical report would need to be met for such a scheme to be effective. This would give the Department of Health the opportunity to reduce costs for the NHSLA, control defendant behaviour and secure representation for injured patients by specialist lawyers at a fair rate of pay’.

Whether or not the government will actually implement this new limit for fixed fees in clinical negligence claims remains to be seen and will not be known for certain until the publication of the consultation paper which we await with anticipation.
The Relationship Between Costs Budgeting and Costs Assessment: *Merrix v Heart of England NHS Foundation Trust*

In the recent judgment of *Merrix v Heart of England NHS Foundation Trust* (Birmingham District Registry, 13 October 2016), Regional Costs Judge District Judge Lumb considered the extent to which the costs budgeting regime in CPR Part 3, fettered the powers and discretion of the Costs Judge on detailed assessment under CPR Part 47.

DJ Lumb pointed out at the start of his judgment, that:

‘Both processes share a common objective to identify reasonable and proportionate costs. However, looking from opposite ends of a procedural timeline they are not necessarily focussed on exactly the same thing’.

The matter was a preliminary issue in a clinical negligence claim and the defendant was the paying party. The claimant submitted that a budget fixed the amount of recoverable costs and can be reduced only if the paying party can show good reason to depart from it. This, it was said, was the meaning behind the words in CPR r. 3.18 which states:

‘In any case where a costs management order has been made, when assessing costs on the standard basis, the court will –

a) Have regard to the receiving party’s last approved or agreed budget for each phase of the proceedings; and

b) Not depart from such approved or agreed budget unless satisfied that there is good reason to do so.

Therefore, said the claimant, if her costs are claimed at or less than the figure approved or agreed for that phase of the budget then they should be assessed as claimed without further consideration.

The defendant’s position was that the Costs Judge’s powers and discretion are not fettered by the budgeted figure for the phase but that the budget is but one factor to be considered in determining reasonable and proportionate costs on assessment. Additionally, it pointed out that costs budgeting was not intended to replace detailed assessment, if this were the case then there would be no test of proportionality for these costs, which is carried out at the detailed assessment stage.

Before giving his judgment, DJ Lumb noted that:

‘Although aspects of costs budgeting have been considered in a number of authorities there appears to be no direct case authority on the relationship between costs budgeting and costs assessment. The debate in the legal profession concerning this issue reflects wide-ranging views and interpretations and the parties in the present case have taken entrenched positions which can only be described as polar opposites’.

Having regard to this, he concluded that the defendants must be correct in its submission that costs budgeting was not intended to replace detailed assessment and that the receiving party’s last agreed or approved budget is just another factor that the Court will have regard to. This the judge said, was clear from the fact that the Rules Committee did not make changes to CPR Parts 44 and 47 to give importance to the budget. Further evidence that there was no intention to preclude the availability of detailed assessment can be found in the Practice Direction. PD 3E which expressly states that in budgeting the Court is not carrying out a detailed assessment in advance. DJ Lumb stated:

‘The words “in advance” must mean that this will be available at the conclusion of the case. PD 3E also states that the hourly rates and time to be expended are for guidance purposes only to assist the Court in setting a budget. The time to consider those in detail must therefore come later, at assessment’.

Instead, he stated that, what must have been intended was that effective costs and case management would greatly reduce the need for detailed assessment of some or all of the parties’ costs by ensuring that the costs budgets were within the range of reasonable and proportionate costs for each phase. In so doing the scope for disagreement should be reduced to a level where a paying party would be unwise to risk incurring the significant costs of the detailed assessment process for what would only be limited potential gains.

Therefore he concluded that the strict answer to the question in issue in this case was that the powers and discretion of a costs judge on detailed assessment are not fettered by the costs budgeting regime save that the budgeted figures should not be exceeded unless good reason can be shown. However, he added:

‘… the full answer to the issue is more nuanced than the defendant’s position of “open season” and complete discretion to attack a bill on detailed assessment, and the claimant’s opportunistic attempt to impose a straight-jacket on the costs judge and claim a fixed figure’.

Therefore, he granted permission to appeal and the claimant representative said it is considering its position on the matter.

**Cleaning Products Contain ‘Potent Allergens’**

A research study published in the journal, Occupational and Environmental Medicine has suggested that genetically modified enzymes used in food, perfumes, medicine and cleaning products are ‘potent allergens’ and should be tested like other potentially hazardous chemicals.
In the study, researchers took blood samples from 813 workers routinely exposed to genetically modified enzymes from working in the food, drinks, chemicals, detergents and pharmaceutical industries. In just under a quarter of the blood samples, they found antibodies, which are proteins produced in response to the presence of the GM enzymes. The most commonly detected antibodies were derived from exposure to alpha amylase, stainzyme, and pancreatinin, which are predominantly used in detergents and home care products. Further to this, the researchers examined a subgroup of 134 workers and found around a third of them had possible allergic symptoms such as runny nose, eye irritation or shortness of breath.

The highest levels of sensitisation was produced by alpha amylase, with antibodies showing up in 44% of workers exposed to it, followed by stainzyme (41%) and pancreatinin (35%). These three genetically modified enzymes are all predominantly used in detergents, cleaning products and homecare products.

These results led the researchers to conclude that:

‘Genetically engineered enzymes are potent allergens eliciting immediate-type sensitisation…The assessment of allergenicity should be mandatory for all new products…Enzymes should be tested like any other potentially hazardous chemical’.

The use of enzymes has increased over recent years, particularly within the food industry as it is used to boost flavours and aromas, including in low-fat foods. As well as creating artificial flavourings, industrial applications for enzyme technology range from cheese ripening through speeding up the baking process to enhancing the power of detergents and medicines.

Night Shifts and Cancer

The World Health Organisation (WHO), in 2007, published a review which identified seven studies suggesting that sleep disruption may be carcinogenic to humans. A number of studies suggested an association between shift work and breast cancer. However, the University of Oxford, funded by the UK Health and Safety Executive, Cancer Research UK and the Medical Research Council, has recently found that ‘working night shifts has “little or no effect” on a woman’s risk of developing breast cancer.’

The review looked at data from 10 different countries and pooled the evidence of three large UK-based studies of post-menopausal women, The Million Women Study, EPIC-Oxford and the UK Biobank. In all three studies, participants were asked about their employment and whether their job involved working night shifts. The answers were categorised into:

- never/rarely
- sometimes
- usually
- always

The participants were followed via records of interest in this analysis were the first diagnosis of breast cancer or death from breast cancer.

Overall, it was found across the three studies, that there was no significant link between night shift work for any number of years and risk of breast cancer. Even when combining these results with the seven non-UK studies included in the previous 2007 WHO review, there was still no evidence that night shift work was associated with breast cancer.

The research did point out that the studies reviewed were all observational studies and so the possibility that other health and lifestyle factors associated with night-shift work, such as obesity or smoking, could increase breast cancer risk still can’t be ruled out.

We review the evidence further in a future feature.

MPs To Lobby Truss Over Whiplash Reforms

We reported in last week’s edition of BC Disease News that the long-awaited consultation on raising the small claims limit and removing general damages for low-value soft-tissue injuries has been delayed, it seems, indefinitely. However, this week it has been reported that a group of Conservative MPs will next week lobby the justice secretary, Elizabeth Truss, to follow through with the proposed personal injury reforms. The group of 10 backbench MPs are eager to point out that this is a delay rather than a cancellation and are due to meet with Ms Truss early next week.

Elsewhere, the Association of British Insurers (ABI) Motor Conference was held this week in which former Labour justice secretary, Lord Falconer, was a guest speaker. He said few people in Parliament were focused on personal injury reform given Brexit, and predicted that Truss would be similarly distracted from the issue. Instead he said, that insurers should focus on investing in fraud detection and taking legal action against those that commit fraud.

The ABI published its report ‘Lifting the Bonnet on Car Insurance’ this week, which sets out what motor insurance premiums pay for. The report highlights that bodily injury claims make up 37% of insurers’ costs despite accounting for only 9% of total motor claims. Given these figures, it is likely that insurers will continue to lobby for the reforms with the ABI putting them at the top of its list of five action points it set to ensure a ‘fairer deal for honest customers’. The full report and the ABI’s five action points can be found here.
Feature
Single Audiometry: A Basis For NIHL Claims Handling Schemes?

“Despite being regularly referred to as the ‘gold standard’, pure tone audiometry, as it currently stands, has a very high degree of potential error, particularly in a clinical environment.”

Marine and Technology Faculty, Southampton Solent University, 2015

“A single determination of hearing threshold level at any frequency must be recognised as only a guess of unknown accuracy.”


INTRODUCTION
If audiometry is properly carried out in accordance with the British Society of Audiology’s (BSA) recommended procedures for pure tone audiometry, then can NIHL be reliably diagnosed based on a single audiogram?

Can NIHL claims handling schemes based upon a single audiogram simplify and speed up the claims process and reduce claim costs?

In a seminar held this week by the Manchester Law Society on NIHL claims (‘What’s all the noise about Noise Induced Hearing Loss’), Dominic Weir of Slater & Gordon, Karen Jackson of Roberts Jackson, Zoe Holland of Zebra LC and HHJ Gore QC advanced arguments in favour of a ‘single trusted audiogram’ during a panel discussion. Such arguments also appear to be finding increasing favour in the defendant community.

In this feature we consider audiometric reliability and the diagnosis of NIHL and why, in our view, single audiometry handling schemes would lead to more paid NIHL claims and re-ignite a currently declining market.

AUDIOMETRIC VARIABILITY
Pure tone audiometry has now been in use for over 90 years and has been described as the ‘Gold Standard’ for the assessment of hearing thresholds. Nevertheless it is accepted not to be a precise science - measurements are susceptible to errors, which may lead to variability in the results, and a lack of reliability. Stephens (1981) found 38 sources of error in audiometric testing.

The American Academy of Otolaryngology - Head and Neck Surgery, list the variables in 4 principle categories and we set out some examples of the sources of error below:

1. Physical variables
   a. Improper calibration of audiometer
   b. Improper placement of earphones
   c. Type of earphones and earphone cushions used
   d. Excessive ambient noise levels in test rooms

2. Physiological variables
   a. Tinnitus
   b. General health of subject, presence of fatigue, colds and ear wax
   c. Collapsed ear canals caused by earphone pressure
3. **Psychological variables**
   a. Motivation of subjects
   b. Attitude to testing
   c. Experience in test taking

4. **Methodological variables**
   a. Tester competence
   b. Testing technique
   c. Order of presentation of frequencies

Measures such as calibration of the test environment, equipment and procedure to ISO standards can reduce the risk of errors.

There are both British and international standards for the test procedures. The BSA has published recommended procedures for pure tone audiometry which are in accordance with the International & British Standard BS EN ISO 8253-1. However, despite the use of these standards and recommended procedures, measurement variability is still inevitable. It is entirely normal to have 5 to 10 dB differences in thresholds - in either direction - between properly conducted hearing tests.

This measurement variability has long been recognised. Chapter 5, section 5.2.3.1 of the Black Book,\(^\text{10}\) states that:

- Repeatability varies from person to person;
- Repeatability is best at 1 and 2 kHz and poorer outside these limits, especially at 6 kHz;
- With 5 dB measurement steps then audiometric variability within the same test (intra-test variability) may be within +/- 5 dB.

As was stated by HHJ Inglis in the Nottingham Textile Litigation judgment at 1st instance,\(^\text{11}\) at paragraph 103:

> "The central tool in diagnosis is the audiogram. Audiograms are taken in steps of 5 dB at each frequency. They are variable and not generally exactly repeatable. Where 2 audiograms taken at about the same time vary, the results where there is variation may reasonably be averaged if the difference is not more than 10 dB. Up to 10 dB is therefore an acceptable margin of error".

It is important to remember that this degree of ‘acceptable margin of error’ can occur where 2 audiograms are performed entirely properly by experienced audiologists within a proper test environment and calibrated equipment and applying BSA recommended procedures in testing.

If one test (or both) is not properly conducted then the margin of error and variability in measured thresholds between tests can be far greater. Some sources of audiometric error can result in better than actual hearing - so for example where a patient can see the audiometer and when a test signal is applied or there is a lack of variation in the test signals so the patient anticipates hearing a sound rather than actually doing so. The vast majority of errors however increase the measured hearing thresholds - in other words show hearing worse than it actually is. As stated by Lawton (1991)\(^\text{12}\):

> ‘...systemic errors [in pure tone audiometry] usually work to elevate the threshold, to make the hearing appear less acute than it really is’.

However, a series of studies carried out by the Maritime and Technology Faculty of the Southampton Solent University between 2013-2015\(^\text{13}\)\(^\text{14}\)\(^\text{15}\), suggest that the degree of accuracy of *properly conducted* audiometry is actually worse than previously thought.

One of these studies aimed to assess how measurements might vary between audiometers in a laboratory environment due to any calibration differences. Calibration requirements of audiometers are set out in various national and international standards,\(^\text{16}\) to ensure their sound outputs are within tolerances of +/- 3 dB at frequencies 125Hz-4 kHz and +/- 5 dB at higher frequencies. Therefore 2 properly calibrated audiometers can differ in their sound outputs by up to 6 dB-10 dB dependent on frequency tested.

The study looked at the variability in sound output from 4 different types of audiometer which had all undergone proper laboratory calibration within the last 3 months. The sound output from the audiometers was measured using a Head and Torso Simulator (HATS) - as pictured below:
The HATS accurately replicates the size and shape of the human head and ears and allows the accurate measurement of sound which would be presented to the ear of a person undergoing audiometry - rather than the measured hearing thresholds of the person. In this way many of the environmental and the subjective sources of error which can occur are avoided.

All the audiometers which used TDH39 headphones were fitted by a qualified audiometrist to the HATS. Three of the audiometers used supral-aural (sit on the outside of the ear) THD39 earphones and one used THD39 earphones with attenuating cups. Attenuating cups are noise excluding cups which can be fitted around the earphones to exclude external noise and are particularly recommended where the ambient noise level of the test environment is not ideal and commonly used in industrial screening situations.
Sound was presented to the HATS using each of the 4 audiometers across the frequencies of 250 Hz, 500 Hz, 1 kHz, 2 kHz, 4 kHz and 6 kHz at assumed sound outputs of 30 dB, 50 dB and 80 dB. Both ‘ears’ were tested and tests were repeated 3 times with the headphones removed and replaced between each test.

In theory each audiometer should present identical tones with the HATS recording the same outputs. Surprisingly the measured outputs of the audiometers, which were apparently presenting the same sound frequency and level to the HATS, showed a high degree of test-retest variability - both within the same audiometer, between the different audiometers and between left and right ‘ears’.

The differences between the means outputs of each of the audiometers were between 3 and 12 dB. The variation in produced tones was greatest both within and between audiometers at 6 kHz with a maximum difference of 20-21 dB - far outside the calibration tolerances of 10dB. The results are reproduced in the table below.

Table: Minimum, maximum, difference and mean measured sound outputs at test levels & frequencies

<table>
<thead>
<tr>
<th>Test Level</th>
<th>Frequency</th>
<th>Min dB Leq</th>
<th>Max dB Leq</th>
<th>Difference Min- Max dB Leq</th>
<th>Mean dB Leq</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 dB</td>
<td>250 Hz</td>
<td>25.6</td>
<td>34.9</td>
<td>9.3</td>
<td>29.9</td>
</tr>
<tr>
<td>30 dB</td>
<td>500 Hz</td>
<td>24.8</td>
<td>36</td>
<td>11.2</td>
<td>29.9</td>
</tr>
<tr>
<td>30 dB</td>
<td>1000 Hz</td>
<td>34.4</td>
<td>41.4</td>
<td>7</td>
<td>39.1</td>
</tr>
<tr>
<td>30 dB</td>
<td>2000 Hz</td>
<td>35</td>
<td>40.9</td>
<td>5.9</td>
<td>38.8</td>
</tr>
<tr>
<td>30 dB</td>
<td>4000 Hz</td>
<td>32.3</td>
<td>37.2</td>
<td>4.9</td>
<td>35.5</td>
</tr>
<tr>
<td>30 dB</td>
<td>6000 Hz</td>
<td>34.1</td>
<td>54.9</td>
<td>20.5</td>
<td>44.4</td>
</tr>
<tr>
<td>50 dB</td>
<td>250 Hz</td>
<td>45.8</td>
<td>54.8</td>
<td>9</td>
<td>50.0</td>
</tr>
<tr>
<td>50 dB</td>
<td>500 Hz</td>
<td>44.8</td>
<td>55.8</td>
<td>10</td>
<td>49.8</td>
</tr>
<tr>
<td>50 dB</td>
<td>1000 Hz</td>
<td>57.3</td>
<td>64.4</td>
<td>7.1</td>
<td>59.6</td>
</tr>
<tr>
<td>50 dB</td>
<td>2000 Hz</td>
<td>55</td>
<td>60.9</td>
<td>5.9</td>
<td>58.7</td>
</tr>
<tr>
<td>50 dB</td>
<td>4000 Hz</td>
<td>52.3</td>
<td>57.2</td>
<td>4.9</td>
<td>55.4</td>
</tr>
<tr>
<td>50 dB</td>
<td>6000 Hz</td>
<td>53.9</td>
<td>74.8</td>
<td>20.9</td>
<td>64.3</td>
</tr>
<tr>
<td>80 dB</td>
<td>250 Hz</td>
<td>75.9</td>
<td>84.9</td>
<td>9</td>
<td>80.5</td>
</tr>
<tr>
<td>80 dB</td>
<td>500 Hz</td>
<td>74.8</td>
<td>86</td>
<td>11.2</td>
<td>80.3</td>
</tr>
<tr>
<td>80 dB</td>
<td>1000 Hz</td>
<td>84.4</td>
<td>91.2</td>
<td>6.8</td>
<td>88.9</td>
</tr>
<tr>
<td>80 dB</td>
<td>2000 Hz</td>
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<td>91.2</td>
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<tr>
<td>80 dB</td>
<td>4000 Hz</td>
<td>82.3</td>
<td>87.2</td>
<td>4.9</td>
<td>86.2</td>
</tr>
<tr>
<td>80 dB</td>
<td>6000 Hz</td>
<td>83.9</td>
<td>104.9</td>
<td>21</td>
<td>94.1</td>
</tr>
</tbody>
</table>

The audiometer using attenuating cups had greater variation than the other audiometers in the study. It also had a significantly higher output level than the other audiometers at a number of frequencies. The authors suggest that a reason for this might be that the use of attenuating cups creates a calibration error. The attenuating cups themselves are likely to introduce a degree of resonance, which will change the frequency response of headphones to the ear.

Further identified causes of variation were the different headband designs and tensions. The audiometer that performed the most consistently was the audiometer with the tightest headphones. These effects are likely to be greater in real world environments due to variability in the sizes and shapes of human heads. In addition, the artificial head used in this study remained still, whereas human heads will probably move during testing, which could cause greater variations.
The authors also commented on the difficulty of positioning the attenuating cups over the ears, due to reduced visibility of the transducer part of the headphone. This variation is also likely to occur in real subjects, which demonstrates a difference between the ‘calibrated’ set up and the ‘clinical’ set up. It is suggested that the position of the headphones is particularly significant at 6 kHz.

The authors concluded that:

(i) To improve the accuracy of audiometry, headband tension needs to be sufficiently high to ensure good coupling between the ear and headphone and different headphones or tensions may be appropriate to different sizes of head;

(ii) Attenuating cups significantly increase variability and should be avoided;

(iii) The high proportion of people with threshold shifts at 6 kHz could be linked to the variation in performance of the headphones when placed slightly differently or with insufficient tension on the ears;

(iv) You can expect variations of up to 21 dB in hearing thresholds at some frequencies if tested in different clinics. You can also expect a high degree of variation for different tests within the same clinic using the same audiometer. ‘Real world’ differences are likely to be greater than shown in the study;

(iv) The degree of variability found within the study is sufficient to cause misdiagnosis of NIHL on a single audiogram;

(v) Despite being regularly referred to as the ‘gold standard’, pure tone audiometry, as it currently stands, has a very high degree of potential error, particularly in a real world environment.

The same authors then followed this study by looking at the variation of measurements in both laboratory conditions and real world/clinical conditions. The methodology for testing laboratory conditions was as described above using the HATS. To test in a clinical/real world environment 13 people were recruited from the University community - some with normal hearing and some with hearing problems. Testing was carried out by a qualified audiometrist in accordance with the BSA recommended procedures for PTA using 3 different audiometers and TDH39 headphones. As expected the variation in clinical conditions (for the 13 test subjects) was even greater than for a laboratory conditions (using the HATS).

At the key frequencies of 3, 4 and 6 kHz the mean differences were between 5-12 dB but the maximum differences were 15 dB, 20 dB and 30 dB respectively. The results are reproduced in the table and figure below.

Table and figure: Maximum and mean variations in sound outputs

<table>
<thead>
<tr>
<th>Frequency Hz</th>
<th>Test-retest variation dB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Max</td>
</tr>
<tr>
<td>500</td>
<td>15</td>
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<tr>
<td>1000</td>
<td>20</td>
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<td>2000</td>
<td>15</td>
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<td>3000</td>
<td>15</td>
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<td>4000</td>
<td>20</td>
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<tr>
<td>6000</td>
<td>30</td>
</tr>
<tr>
<td>8000</td>
<td>35</td>
</tr>
</tbody>
</table>

The authors stated:

‘All frequencies had a maximum error of at least 15 dB in the clinical tests, which brings into question the accuracy of clinical pure tone testing as the primary mode of hearing screening, as this degree of error is sufficient to cause misdiagnosis’.
CONCLUSIONS

When using the CLB Guidelines as a diagnostic framework for NIHL, small differences in hearing thresholds matter. A 5-10 dB difference at a single threshold can change a +diagnosis to a –diagnosis.

The Institute of Sound & Vibration Research in a 2015 Technical Report summarised the position on diagnosis of NIHL based on a single audiogram as follows:

“A single determination of hearing threshold level at any frequency must be recognised as only a guess of unknown accuracy.”

“For an individual test subject, a single audiogram is an unconfirmed determination of that individual’s state-of-hearing in both ears. Put more starkly, a single audiogram is a guess.”

The recent studies by Southampton Solent University suggest that the typical variability of pure tone audiometry is greater than previously thought. Differences far greater than the 10 dB ‘accepted margin of error’ may in fact be typical. These differences arise even where the audiometry is performed in accordance with BSA Recommended procedures for pure tone audiometry. Where audiometry is sub-standard then expect the differences to be even greater and showing worse than true hearing thresholds.

Let’s consider the findings of these recent studies in the context of the current NIHL market:

1. Claims volumes have been falling over the last 12 months - see 144 of BC Disease News (here) and the UK Deafness Working Party Report. Anecdotally all insurers appear to be reporting significant falls in claims volumes;

2. The hearing of many claimants is difficult to distinguish from those typical of an aged population which has not been exposed to noise - see our analysis of some 10,000 claims in edition 124 of BC Disease News (here), where around 50% of claimants arguably had no more than normal hearing for a non-exposed/aged population;

3. Nearly 60% of claims involved notches/bulges of between 10-19dB. Or, expressed another way, 60% of claims are diagnosed based on notches/bulges that are within the range of normal audiometric error which could disappear on repeat testing;

4. In many cases, if there is any NIHL is it sufficient to give rise to damages? Applying the new LCB Guidelines on disability, then up to 1/3rd claims arguably have such NIHL that is so small as to be considered de minimis. (Full details on the LCB Guidelines and their impact can be found in the BC Legal Guide here);

5. The quality of claims appear to have deteriorated over the last few years. More claims are spurious and more successfully defended - see the above report;

6. Analysis of claimant audiograms shows that + diagnosis of NIHL applying the CLB Guidelines has increased from c.50% in 2011 to c. 90% today. Simple CLB diagnostic tools offer little safeguard to defendants in today’s market-analysis must be far more sophisticated. A defendant’s ability to obtain repeat audiometry and its own medical evidence is a key mechanism to control the market and ensure the current high repudiation rates are maintained.

In our view, single audiometry handling schemes would:

(i) result in over-diagnosis of NIHL;
(ii) lead to reduced repudiation rates and more claims paid;
(iii) provide much needed cash flow to claimant organisations, and:
(iv) re-ignite a currently declining market.

Ask yourself what are the benefits of adopting a single audiometry handling scheme in the current market?

In a future feature we look at the results of repeat audiometry obtained by BC Legal. In what % of claims is the audiometry consistent and reliable such that diagnosis can be validated? In what % of claims does repeat audiometry show thresholds significantly different from the claimant audiometry? In how many of such claims does the repeat audiometry provide a defence on causation?

[NOTE: OUR TEMPLATE NIHL LETTERS HAVE BEEN UPDATED AND CAN BE FOUND HERE]
References


5 British Society of Audiology, ‘Recommended Procedure: Pure-Tone Air-Conduction And Bone-Conduction Threshold Audiometry With And Without Masking’ (British Society of Audiology, 9th September 2011, Amended February 2012).


7 Dominic Weir is Chair of the CJC Noise-induced Hearing Loss Working Group and Karen Jackson and Zoe Holland both sit on the Committee which we previously reported on in edition 105 of BC Disease News.


11 [2007] EWHC B1 (QB)


17 https://bksv.com/Products/transducers/ear-simulators/head-and-torso/hats-type-4128d?src=fnt

18 See not only study but Letter to Editor in, Barlow CA et al. Concerns with amplitude variation in calibrated audiometer systems in clinical simulations Noise Health 2015;17:384-5.


21 UK Deafness Working Party, 'Summary Data – 2015(Q4)' (Institute and Faculty of Actuaries).

Disclaimer

This newsletter does not present a complete or comprehensive statement of the law, nor does it constitute legal advice. It is intended only to provide an update on issues that may be of interest to those handling occupational disease claims. Specialist legal advice should always be sought in any particular case.

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